STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120792-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _12th_ day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On April 22, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on April 29, 2011.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on May 9, 2011.

The issue in this external review can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner is enrolled for health care coverage through a group plan underwritten by BCBSM. Her benefits are defined in BCBSM's *Community Blue Group Benefits Certificate* (the certificate).

From January 19 through May 6, 2010, the Petitioner underwent surgery and received other medical services from XXXXX, MD, DMD, in XXXXX. Dr. XXXXX does not participate with BCBSM or a local Blue Cross or Blue Shield (BCBS) plan in XXXXX. The Petitioner, unhappy with the amount BCBSM reimbursed her for Dr. XXXXX's services, appealed BCBSM's decision through its internal grievance process. BCBSM held a managerial-level conference on January 10, 2011, and issued a final adverse determination dated February 14, 2011.

III. ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's care provided by Dr. XXXXX?

IV. ANALYSIS

According to the Petitioner, the Petitioner stated she paid Dr. XXXXX $37,500 for surgery and related care to resolve her severe temporomandibular joint (TMJ) problems. BCBSM reimbursed her for $3,968.40, leaving her responsible for the balance of $33,531.60. The Petitioner believes that the amount she received from BCBSM for her TMJ reconstruction, performed by a world-renowned surgeon, was substantially lower than it should have been. She argues that BCBS of XXXXX used flawed data to determine the usual and customary fees BCBSM relied on to make its payment to her. She believes BCBSM's approved amounts for her care should be increased considerably.

BCBSM argues the Petitioner was aware that Dr. XXXXX was a nonparticipating provider when she chose to treat with him; the Petitioner does not claim otherwise. Thus, this case illustrates the problems that result when medical services are received from a nonparticipating provider.

Under the certificate, the least out-of-pocket expense is incurred if services are received from providers who participate with BCBSM or a local BCBS plan. The certificate (page 4.32) warns of the possible consequences if an enrollee uses a nonparticipating provider:

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . . (emphasis added)
>
> * * *
>
> **NOTE:** Because nonparticipating providers[1] often charge more than our maximum payment level, our payment to you may be less than the

1 "Nonparticipating provider" is defined in the certificate as "Physicians or other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. . . . "

amount charged by the provider.

The certificate (p. 4.2) also explains that BCBSM's payment is based on its "approved amount" for each covered services. "Approved amount" is defined in the certificate as "The lower of the billed charge or [BCBSM's] maximum payment level for the covered service. . . ."

BCBSM pays its approved amount to both participating and nonparticipating providers. However, participating providers have entered into a contractual agreement with BCBSM to accept the approved amount as payment in full for covered services provided to BCBSM's enrollees. By contrast, nonparticipating providers have no contractual obligation to accept the approved amount as payment in full and may bill a BCBSM member for any balance over BCBSM's approved amount.

Initially, the Petitioner's claims were processed as "out-of-network," i.e., services received from a nonparticipating provider. However, because she had a referral for the services from a participating provider, the claims were reprocessed as "in-network." Since the services were performed in XXXXX, BCBSM used the maximum payment level of the XXXXX BCBS plan to determine its approved amount. Categorizing the claims as "network" claims does not mean that the provider charge would be paid in full; it only means that certain sanctions for out-of-network services are waived (e.g., copayments, coinsurance, and deductibles). BCBSM still only pays its approved amount for the services.

As the Petitioner discovered, BCBSM's approved amount was considerably less than Dr. XXXXX's charge. If Dr. XXXXX had participated with BCBSM or the local BCBS plan, he would have accepted BCBSM's approved amount as payment in full and could not have billed the Petitioner for the difference between his charge and the approved amount.

The certificate requires BCBSM to pay only its approved amount for covered services. It does not guarantee that more will be paid to a nonparticipating provider.

Lastly, regarding the Petitioner's contention that the XXXXX BCBS plan's payment levels were too low, the Commissioner has no authority to evaluate the business practices of the XXXXX BCBS plan.

After reviewing the record, the Commissioner concludes that BCBSM covered Dr. XXXXX's services correctly under the terms and conditions of the certificate. There is nothing in the certificate that requires BCBSM to pay more than its approved amount.

V. ORDER

BCBSM's final adverse determination of February 14, 2011, is upheld. BCBSM is not required to pay any additional amount for the Petitioner's care from Dr. XXXXX.

This is a final decision of an administrative agency. Under MCL 550.1915(1), any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner